Special Articles and Association Notes

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The Resuscitation of the Apparently Drowned*

The season is now approaching when we shall be again confronted with a distressing series of drowning accidents. Much attention has been directed to the automobile accident; not so much to the drowning accident. In the matter of prevention the human element has to be considered in both. Ignorance, carelessness, foolhardiness, physical ailment, all play their parts, and, human nature being what it is, it is hardly likely that these factors can be eliminated to any appreciable extent. This leaves us with the question as to what can be done to save life in the face of a potential drowning case. Here the doctor and the first-aid worker come into the picture. It is essential that both of them should be conversant with the latest and best ideas that have been developed.

It is safe to say that the first thought of the life-saving worker is to initiate artificial respiration. So far, so good, but is sufficient thought given to the details of this procedure, attention or inattention to which will make all the difference in the result? Again, is artificial respiration carried out long enough? A common practice is to continue the procedure for an hour or two and then if the heart sounds cannot be heard with the stethoscope to pronounce the patient dead. This we submit is rather perfunctory. There is excellent authority for the statement that artificial respiration should be carried out for many hours if need be, and not discontinued *until rigor mortis has set in.*

This most important subject was brought to the attention of our Association at the annual meeting in June, last year, when Dr. Gordon Bates, of Toronto, gave an earnest and arresting address which immediately went home. At a meeting of the incoming Executive, held a day or two after, the following resolution was passed—

> "Whereas it has been brought to the attention of this Association that methods of resuscitation in cases of apparent death from drowning, electrical shock, carbon monoxide poisoning and other conditions are often inadequate and are given at a time when there is still a chance of recovery: And whereas there is evidence that long-continued resuscitation will produce a larger percentage of recoveries:
>
> "Therefore be it resolved that a summary of this evidence be published in the *Journal* as soon as possible, and be transmitted to all Divisions and Branches of this Association in order to give the subject widest publicity among the medical profession."

In conformity with the spirit of this instruction the *Journal* published in its August issue a paper by Drs. Bates, Gaby and MacLachlan, members of the Committee on Artificial Respiration, Health League of Canada, which developed the matter farther.[1] This paper is a plea for the more prolonged application of resuscitation measures, and endorses the recommendation that if restoration is not quickly effected artificial respiration should be kept up until rigor mortis sets in. Rigor mortis is the most convincing proof that death has ensued; the stethoscope is *not reliable* in these cases. The authors make the remarkable statement that "It is possible for a person to have been under water for up to half an hour and still live." Three instances are cited. The lesson is obvious.

And now comes a paper, also of first-class importance, dealing with the experimental side of the subject.[2] It appears in this issue of the *Journal* and deserves the attention of all our readers. Coming from workers at the Banting Institute, it is authoritative. Such subjects as the respiratory and swallowing reflexes, reflex laryngeal spasm, blood pressure, CO_2 content of the blood, the condition of the heart, lungs and stomach post mortem are subjects dealt with scientifically; also, the possible curative effects of various drugs and mechanical procedures.

* Reprinted from The Canadian Medical Association Journal, 40, 487-488, 1939, by kind permission of the Editor.

These authors conclude as follows. "As a result of our experiments we consider that *prompt, adequate* and *prolonged* artificial respiration is the fundamental treatment for drowned, asphyxiated or electrocuted persons." The italics are ours. Every adjective deserves close consideration.

It may be added that in the case of artificial respiration manoevres seconds count. To interrupt the movements even momentarily may spell failure. The mouth and air passages should be cleared as far as possible of foreign matter, and to ensure a free passage for the air on account of the laryngeal spasm so frequently present, a semi-rigid tube should be passed through the larynx. The body should be placed in a semi-prone position, with the head turned to one side and somewhat lower than the rest of the body. Appropriate resuscitation exercises should then be instituted.

Lougheed, Janes and Hall have tried a number of drugs, including adrenalin, nicotine, amyl nitrite, and the mixture of CO_2 and O_2 known as carbogen, for the resuscitation of drowning animals. They think that carbogen is very valuable. The only other agent that need be used is amyl nitrite, which may be given from "perles" and administered during the inspiratory phase of the artificial respiration movements. Adrenalin appears to be positively dangerous.

Such studies as these are of the utmost value, and we may confidently expect that strict attention to the lesson of the findings will result in the saving of many more lives in the future.

A.G.N.

1. Bates, G., Gaby, R. E. and MacLachlan, W.: The need for prolonged artificial respiration in drowning, asphyxiation and electric shock, Canad. M. Ass. J., 1938, 39: 120.

2. Lougheed, D. W., Janes, J. M. and Hall, G. E.: Physiological studies in experimental asphyxia and drowning, Canad. M. Ass. J., 1939, 40: 423.

Meeting of Executive Committee

Minutes of a Special Meeting of the Winnipeg members of the Executive Committee of the Manitoba Medical Association held in the Medical Arts Club on Tuesday, May 2nd, 1939, at 6.30 p.m.

Present.

Dr. W. E. Campbell	Dr. S. G. Herbert
Vice-President	Dr. E. W. Stewart
(Chairman)	Dr. C. E. Corrigan
Dr. C. W. Burns	Dr. O. J. Day
Dr. Geo. Brock	Dr. C. W. MacCharles.

The Chairman explained that the meeting had been called for the purpose of dealing with some items of business that had been left over from the last full meeting of the Executive Committee.

Business Arising Out of the Minutes and Unfinished Business

Federation.

The secretary reported that as instructed at the meeting of the Executive Committee on January 17th, 1939, he had written to the Chairman of the Committee on Constitution and By-Laws of the Canadian Medical Association, to advise him of the report of the Committee on Federation of the Manitoba Medical Association which was adopted by the Executive Committee. In reply he had received a letter from Dr. Harris asking if it would be satisfactory if he were to carry on correspondence with Dr. McKenty's Committee to see if some satisfactory compromise could be arrived at. The secretary had replied on April 6th that it was the intention of the Executive Committee of the Manitoba Medical Association that this discussion should be continued.

It was moved by Dr. S. G. Herbert, seconded by Dr. C. E. Corrigan: THAT the secretary's letter be approved. —Carried.

Letter from Dr. Strong
Re Compensation Cases.

The secretary stated that the Special Committee appointed to deal with this matter had made a report and had suggested that Dr. Strong be asked to express his opinion on this report. He had written to Dr. Strong asking him for his comments on the report, but to date no reply had been received.

It was decided that the secretary should be instructed to communicate with Dr. Strong again and that the matter be left over for the next regular meeting of the Executive Committee.

Milk Depot.

The question of the investigation of the Milk Depot had been raised by Dr. Gordon Chown at the Annual Meeting of the Manitoba Medical Association.

After considerable discussion it was moved by Dr. C. E. Corrigan, seconded by Dr. E. W. Stewart: THAT the Vice-President should appoint a Special Committee to investigate the operations of the Milk Depot and report to the Executive Committee. —Carried.

The Vice-President then named the following a Committee to deal with this matter:

Dr. W. F. Tisdale	Dr. O. J. Day
(Chairman)	Dr. S. A. Boyd.

Berlo School.

This correspondence with regard to examination of children at this school was discussed in some detail, and it was finally moved by Dr. C. E. Corrigan, seconded by Dr. Geo. Brock: THAT it be ascertained if any arrangements had been made for a clinic at this school, and if not, the secretary be instructed to advise the sister in charge of the school that arrangements for such a clinic are

the responsibility of the municipal authorities, as this is an organized district. —Carried.

Relief Cases in Unorganized Territories.

The secretary reported that in November he had been instructed to secure from the Department of Health a record of the scale of fees paid for medical care of citizens on relief in unorganized territories. A record of this scale of fees had been furnished by the Deputy Minister.

The secretary also read a letter from Dr. Peacock of Roblin citing an instance where in view of the type of travelling required in attending a particular case, the actual fee paid for services was very small.

A motion was passed instructing the secretary to secure further information.

Hospital Aid Act.

The secretary reviewed the minutes and correspondence with regard to this problem, including a letter signed by the Hon. Minister of Health which was sent to the medical officers of health, secretary-treasurers of municipalities and Reeves and Mayors of Municipalities on October 7th, 1937.

The problem chiefly involved was with regard to sending in to public wards of hospitals patients who should be able to pay the regular hospital charges, and also medical fees.

Dr. Burns reported that at the last annual meeting of the Manitoba Hospital Association he had brought this matter to the attention of the delegates.

It was suggested that when patients apply for accommodation in the public wards that it might be possible to have a form available which they should sign, stating that they were unable to pay the regular cost of hospital accommodation or medical fees.

A motion was passed instructing the secretary to secure further information with regard to this suggestion.

Representative on Workmen's Compensation Referee Board.

The secretary read a letter from the Assistant Commissioner of the Workmen's Compensation Board dated February 24th, 1939, asking the Manitoba Medical Association to suggest the name of a medical man to act as Chairman of the Medical Appeal Board. This had been considered at a special meeting of the officers on March 3rd, 1939, and it was decided to suggest the name of Dr. J. A. Gunn. A letter to this effect had been sent to the Workmen's Compensation Board under date of March 3rd.

The Assistant Commissioner had also requested that a name should be suggested for the office of Vice-Chairman and that a panel of names for the third member of the Medical Appeal Board should also be forwarded. At the special meeting of the officers it was decided to defer action until the meeting of the Executive Committee.

The secretary pointed out that the arrangements entered into between the Workmen's Compensation Board and the Manitoba Medical Association in 1934 had never been strictly adhered to as the Manitoba Medical Association had failed to forward names for the various offices each year.

It was moved by Dr. Geo. Brock, seconded by Dr. E. W. Stewart: THAT the secretary and the treasurer interview the Commissioner or Chief Medical Officer of the Workmen's Compensation Board and discuss with him the most suitable arrangements for the Medical Appeal Board particularly as to whether or not the chairmanship should be changed each year as suggested in the original agreement in 1934. —Carried.

The treasurer and the secretary were also instructed to submit to the next meeting a tentative list of names for the Medical Appeal Board of the Workmen's Compensation Board.

Dr. Davidson's Research Work.

The secretary reviewed the minutes and correspondence with regard to this problem.

It was moved by Dr. C. E. Corrigan, seconded by Dr. C. W. Burns:

THAT this correspondence be referred to the Medical Research Committee of the University of Manitoba, and

THAT the Winnipeg Medical Society and the Honorary Attending Staff of the St. Joseph's Hospital should be advised of this action.

—Carried.

King George V Silver Jubilee Cancer Fund.

The secretary read a letter from Dr. Routley, secretary of the Canadian Medical Association, dated November 17th, 1938.

It was moved by Dr. C. W. Burns, seconded by Dr. Geo. Brock: THAT this letter be filed.

—Carried.

Appointment of Representatives of Cancer Relief and Research Institute.

At a special meeting of the officers held on March 3rd, 1939, the question of the appointment of representatives from the Manitoba Medical Association to the Cancer Relief and Research Institute, had been discussed. The original appointments from the Manitoba Medical Association had been made on January 10th, 1936. Three names had been submitted with one appointment for three years, one for two years and one for one year. Consideration of the Cancer Relief Act suggested that all appointments might have to be for three years. On examining the correspondence, it was found that there was no record of any appointments having been made subsequent to June 10th, 1936.

It was moved by Dr. C. W. Burns, seconded by Dr. S. G. Herbert: THAT the secretary be instructed to ascertain the names of the members of the Board, the organizations by whom they

had been appointed, and if the appointments could be made for less than three years, or if all appointments were required to run for three years. —Carried.

Letter from Dr. Ross of the Sanatorium Board of Manitoba.

The secretary read a letter from Dr. Ross under date of January 10th, 1939, in which Dr. Ross asked if it would be possible for a group of physicians to form a division of the Manitoba Medical Association for the study of tuberculosis.

It was moved by Dr. O. J. Day, seconded by Dr. S. G. Herbert: THAT the secretary be instructed to write to Dr. Ross quoting Article 3 of the constitution, and also that he obtain copies of the constitution and by-laws of the older provincial association so that a study of this might be made with a view to revision of the constitution of the Manitoba Medical Association. —Carried.

Canadian Medical Association Senior Members.

At the meeting of the Executive Committee on January 17th a committee consisting of the secretary and Dr. Ross Mitchell had been appointed to select the names to be suggested to the Canadian Medical Association for senior membership, as requested in a letter from Dr. Routley dated November 18th.

The secretary reported on the recommendations made by the special committee.

It was moved by Dr. C. W. Burns, seconded by Dr. E. W. Stewart: THAT the names suggested by this Special Committee be approved. —Carried.

Special Liason Committee Re Hospital Problems.

The secretary reviewed the correspondence with regard to the suggestion of Dr. Harvey Agnew that a Liason Committee between existing organizations be formed to discuss hospital problems. He advised that this had been discussed at a special meeting of the officers held in March and that a letter had been sent to Dr. Agnew giving tentative approval of the Manitoba Medical Association to this suggestion.

It was moved by Dr. O. J. Day, seconded by Dr. S. G. Herbert: THAT the action of the officers and the correspondence be approved, and that Dr. Ross Mitchell be appointed a delegate to the meeting of this Committee. —Carried.

Letter from Dr. S. Bardal.

The secretary read a letter from Dr. Bardal suggesting that a member of the Executive Committee of the Manitoba Medical Association should be permitted to attend all meetings and conferences called for the purpose of discussing matters pertaining to medical economics.

After discussion it was moved by Dr. C. W. Burns, seconded by Dr. O. J. Day: THAT the secretary be instructed to write to Dr. Bardal stating that the members of the Executive Committee approved of the principle suggested in his letter, and agreed that it would be advisable to ask the approval of the Minister of Health for such an arrangement, but that as Dr. Bardal's letter was open to various interpretations that his suggestion with regard to such a delegate not being a member of the Committee on Sociology be clarified. —Carried.

Tourist and Convention Bureau.

The secretary read a letter from the Tourist and Convention Bureau suggesting that they might invite the Inter-State Post-Graduate Medical Association to hold a meeting in Winnipeg. It was suggested that facilities for such a meeting in Winnipeg might not be adequate, and after considerable discussion it was moved by Dr. C. W. Burns, seconded by Dr. O. J. Day: THAT the secretary be instructed to correspond with the Inter-State Post-Graduate Medical Association and find what their requirements for such a meeting might be, and that the secretary also write to the Tourist and Convention Bureau and advise them of this action. —Carried.

New Business

Medical Meetings in Canada.

The secretary read a letter from the secretary of the Canadian Medical Association under date of March 22nd advising that at a meeting of the Executive Committee of the Canadian Medical Association the following motion was passed:

> "THAT Medical Associations and organizations with head offices outside of Canada, contemplating holding meetings in any Province of Canada, be requested to communicate with the Canadian Medical Association or the appropriate Provincial Medical Association as to the time of meeting, to avoid conflict with meetings of national or provincial bodies."

It was moved by Dr. C. E. Corrigan, seconded by Dr. C. W. Burns: THAT the motion of the Executive Committee of the Canadian Medical Association be approved. —Carried.

Annual Meeting of Canadian Medical Association, Winnipeg, 1941.

The secretary read a letter from the secretary of the Canadian Medical Association advising that the Executive Committee of the Canadian Medical Association had passed the following motion:

> "THAT the annual meeting in Winnipeg in 1941 be held during the week of June 22nd."

Annual Meeting of Manitoba Medical Association.

Motion Pictures: The secretary reported that it had been suggested that medical motion pictures might be a valuable asset for the annual meeting in September. He reported he had been in corres-

pondence with various organizations to find what pictures might be available.

It was moved by Dr. C. W. Burns, seconded by Dr. O. J. Day: THAT this correspondence be referred to the Programme Committee. —Carried.

Exchange of Speakers with British Columbia: The secretary reported that it had been suggested that in addition to the speakers from Eastern Canada it might be an advantage to exchange speakers for the annual meeting between the British Columbia Medical Association and the Manitoba Medical Association, and reviewed the correspondence with regard to this matter.

It was moved by Dr. C. W. Burns, seconded by Dr. O. J. Day: THAT the Committee approve of the suggestion of exchange of speakers between Manitoba and British Columbia for the annual meetings, and that if necessary the expense of one speaker be borne by the Manitoba Medical Association, and that this question should be referred to the Programme Committee. —Carried.

Letter from Dr. Patch.

The secretary read a letter from Dr. Patch, President-Elect of the Canadian Medical Association, expressing his thanks for receipt of the Manitoba Medical *Review,* and advising that he was looking forward with pleasure to attending the meeting of the Manitoba Medical Association.

Physiotherapy.

The secretary reported that a communication had been received from a group of people in which it was stated that a Manitoba Association of Physiotherapists had been formed. The secretary had been in communication with one of the members of this group and was informed that this was a voluntary organization but it was the intention of the group to secure a charter from the provincial government, and the members would welcome the co-operation of the medical profession in forming their organization.

The secretary also reported that he had found out that it had been arranged that the Nurses Central Directory should arrange appointments for the members of this group when requested to do so, and that there was nothing to prevent a lay person arranging directly with the Nurses Central Directory for treatment by one of these physiotherapists. It was pointed out that if this practice were carried out it would mean members of this group would be allowed to carry on medical practice.

It was moved by Dr. Geo. Brock, seconded by Dr. C. E. Corrigan: THAT an Orthopaedic Committee be appointed to investigate this problem and report back to the Executive Committee. —Carried.

The Chairman named the following Committee to act:

Dr. A. P. MacKinnon (Chairman) Dr. George Ryan.

Letter from Dr. C. H. A. Walton Re Pollen Survey.

The secretary read a letter from Dr. Walton under date of March 7th, asking for the support of the Manitoba Medical Association towards securing the co-operation of the Department of Health and the Department of Education to carry on a pollen survey in Manitoba.

It was moved by Dr. S. G. Herbert, seconded by Dr. C. E. Corrigan: THAT this correspondence be referred to the Medical Research Committee of the University of Manitoba. —Carried.

Appointment of Delegates on Canadian Medical Association Council.

The secretary reviewed the correspondence with regard to membership on the Council of the Canadian Medical Association. It was decided to instruct the secretary to secure further information with regard to members of the Manitoba Medical Association who might be attending the annual meeting of the Canadian Medical Association.

Radiological Services in Group Hospitalization Plans.

The secretary read a letter from the secretary-treasurer of the Canadian Association of Radiologists under date of March 13th criticizing the arrangements entered into under some plans of group hospitalization, whereby the services of radiologists were supplied by the hospital concerned.

The secretary was instructed to obtain further information from local radiologists, and that the matter be considered at the next meeting of the Executive Committee.

Letter from Medical Library Association.

The secretary read a letter from the secretary of this association dated March 8th, and it was moved by Dr. Geo. Brock, seconded by Dr. S. G. Herbert: THAT the letter be filed. —Carried.

Letter from Dr. R. D. Ferguson.

A note from Dr. Ferguson was read by the secretary. It was suggested that the question of making life memberships should be brought up at the next annual meeting of the Manitoba Medical Association. It was decided to defer consideration of this problem until the next regular meeting of the Executive Committee.

Letter from Dr. Trimble.

The secretary read a letter from Dr. Trimble suggesting that the northern part of the province might have more representation on the Executive Committee, and his reply.

It was decided that the secretary should communicate with Dr. Trimble again, and that the matter be discussed at an executive meeting.

The meeting then adjourned.

Department of Health and Public Welfare

NEWS ITEMS

THE PREVENTIVE ASPECTS OF VENEREAL DISEASES

In view of the special interest being taken in various parts of the province relative to the prevention of the venereal diseases, the Department thought the following article by Dr. Alfred T. Osgood, Consulting Urologist, Bellevue Hospital, New York City, would be opportune:

"The physical, mental, moral, social and economic damage wrought by syphilis and gonorrhea are matters of general knowledge, and unfortunately the sad personal experience of one or more members of nearly every family in the land. It is scarcely needful here to rehearse the menace to individuals and to the public health of venereal diseases. Statistics, we know, tell only part of the story of their prevalence, with 50,000 new cases of syphilis in New York City, and 500,000 new cases in our country each year, and the conservative estimate of twice as many cases of gonorrhea. How shall we estimate the vast number of those who are unaware of their diseases? The number of those who do not submit to examination, cases incorrectly diagnosed, or the number of those who find diagnosis and treatment in the drug store and from the quack?

"The problem of prevention has been fully recognized by the medical profession, by private, public and governmental health agencies for generations.

"The greatest restriction upon the prevention and control of these diseases up to the present time has been what is designated as 'public opinion.' It has long been maintained that public opinion would not countenance the enforcing of laws to effectively handle this problem in the same way that other communicable diseases have been managed. This great hindrance to effective control in this country is based upon the stigma of moral dereliction implicit in every case, with shielding of the patient by his medical attendant who is bound to preserve professional confidence.

"But gradually a change has been evolving in the minds of the public. With the diffusion of knowledge concerning these diseases and their treatment, a more intelligent attitude toward them has come about. Public opinion now better informed as to what a scourge they are, how they have thrived under concealment, and how they may be treated and controlled, has finally awakened to the importance of strenuous efforts towards restricting them. Within recent years public spirited citizens, welfare workers, district nurses, and some outstanding physicians and other health-servants of this public have aroused a wave of protest against the neglect of these diseases which is assuming tidal proportions. This rapidly growing interest in social hygiene problems is manifest by the very large numbers brought together for the study of this subject on Social Hygiene Day and by the frequent meetings in all parts of this country because of interest in this vital health problem. Legislators have been brought to the point of passing laws concerning them which are making possible definite progress for their limitation. States have passed laws requiring evidence of freedom from syphilis in the case of each party to a marriage contract before the license therefor will be issued. Many who have labored valiantly in years gone by to bring about this changed point of view have passed away, but their influence still prevails and the work that they started is still indefatigably carried on now by individuals and by private and governmental public health forces.

"The achievements in the control of these diseases by the army and navy of the United States during the World War demonstrated what can be accomplished in well controlled bodies of men. Also the brilliant results obtained through recent years in the Scandinavian countries, as well as the good effects of the English plan, have shown that this country has been the laggard in this field of preventive medicine wherein organized, concerted effort can produce results of inestimable value.

"One great stumbling block, however, has been the failure to compel the known source to comply with health regulations, and to compel compliance with directions against its further extension. This seems to be the key to a large part of the problem of prevention. Ways and means must be provided for the continuance of the protection of the victim from publicity and, the strict confidential relation between the physician and his patient must be preserved, but on the other hand, the source of each case of infection must be amenable to law for the protection of the public health, and the ignorant, careless, irresponsible, infectious case must also be made amenable to the police powers of a board of health when that is found to be necessary. This is the method pursued in the case of such diseases as smallpox, the plague, diphtheria, etc., and a method acting with equal force must be devised and applied if these diseases are to be controlled. This is what has been done to effect the reduction of syphilis to a minimum in the compact and well regulated smaller countries such as Denmark and Sweden. The problem, of course, is very much more complex here.

"We have in this country no sweeping epidemics of smallpox, cholera, or bubonic plague. The pest holes where these diseases may originate in this country are isolated, communications are restricted and the public is protected. The time should come when health authorities faced with a focus of any communicable disease will exercise their authority undeviatingly supported by public funds and intelligent public opinion.

"We know enough about syphilis, its prevention and control and its treatment, to limit it enormously, provided the knowledge and the facilities at hand were utilized wisely and to the fullest extent. With regard to gonorrhea there are difficulties which make it less amenable to control. We are at present greatly encouraged by two recent methods of treatment for gonorrhea which offer more promise than any which we have possessed heretofore. These are treatment with sulfanilamide and with hyperthermia. Each of these methods presents important problems for searching scientific investigation before the favorable reports concerning their effects can be placed upon a firm basis. Funds for this purpose should be found. Hyperthermia can be applied to only a few selected cases. It demands hospitalization, careful observation, costly apparatus, prolonged individual attention on the part of the physician and nursing staff, and is not without risk. It is not applicable to the vast number of cases at the present time. Complement fixation test for gonorrhea is, as yet, by no means as reliable as the Wassermann and allied tests for syphilis."

COMMUNICABLE DISEASES REPORTED

Urban and Rural - April, 1939

Occurring in the Municipalities of:

Mumps: Total 149—Winnipeg 132, Kildonan East 6, Unorganized 3, Morris Town 2, Morris Rural 2, Brandon 1, Brokenhead 1, St. James 1, Wawanesa 1.

Influenza: Total 88—Brandon 1, Unorganized 1, Winnipeg 1 (Late Reported: February, Brandon 2,

St. Boniface 2, Birtle Town 1, Montcalm 1, Mossey River 1, Oakland 1, Rockwood 1, Rossburn Rural 1, Turtle Mountain 1; March, Brandon 42, Unorganized 32).

Scarlet Fever: Total 79—Brandon 25, Winnipeg 12, Ste. Rose Municipality 6, Souris Town 5, Unorganized 4, Virden 3, Transcona 3, Thompson 2, Morton 2, Coldwell 1, Cypress North 1, Daly 1, Fort Garry 1, Kildonan East 1, Kildonan West 1, Morris Town 1, Ochre River 1, Saskatchewan 1, Selkirk 1, Shoal Lake Village 1 (Late Reported: March, Portage Rural 4, Souris 1, Wallace 1).

Chickenpox: Total 70—Flin Flon 25, Winnipeg 15, St. Francois Xavier 5, Silver Creek 3, Kildonan East 7, St. Boniface 2, Unorganized 2, Whitewater 2, Brandon 1, La Broquerie 1, Montcalm 1 (Late Reported: February, Unorganized 6).

Whooping Cough: Total 56—Winnipeg 25, Lawrence 10, Kildonan West 6, St. James 5, Unorganized 5, Ethelbert 1, McCreary 1, Swan River Rural 1 (Late Reported: February, Coldwell 1; March, St. Boniface 1).

Lobar Pneumonia: Total 23—Portage City 4, Unorganized 2, Brandon 1, Brokenhead 1 (Late Reported: February, Argyle 1, Brandon 1, Carberry Town 1, Kildonan West 1, Lorne 1, Minitonas 1, Portage City 1, Ritchot 1, St. Anne 1, St. Boniface 1, Transcona 1, Unorganized 1, Wallace 1; March, Unorganized 2).

Smallpox: Total 18—Boulton 8, Dauphin Town 2, Swan River Town 2, Shellmouth 1 (Late Reported: February, Swan River Rural 1; March, Boulton 4).

Measles: Total 14—Morden Town 6, Winnipeg 5, Boissevain 2 (Late Reported: March, Strathcona 1).

Tuberculosis: Total 13—Winnipeg 10, Boulton 1, Morris Rural 1, St. Laurent 1.

Diphtheria: Total 11—Winnipeg 5, Selkirk 3, Argyle 1, St. Boniface 1, The Pas 1.

Erysipelas: Total 8—Winnipeg 6, Brandon 1, Rockwood 1.

German Measles: Total 7—Brandon 2, Rivers 1 (Late Reported: March, Unorganized 4).

Puerperal Fever: Total 2—(Late Reported: February, Binscarth Village 1, Unorganized 1).

Septic Sore Throat: Total 2—Virden 1 (Late Reported: February, Unorganized 1).

Trachoma: Total 1—Rhineland 1.

Typhoid Fever: Total 1—St. Anne 1.

Diphtheria Carriers: Total 1—Flin Flon 1.

Venereal Disease: Total 109—Gonorrhoea 64, Syphilis 45.

REPORTING OF COMMUNICABLE DISEASES

We are quoting herewith extracts received in a letter from Mr. F. J. Russell, Statistician, Dominion Bureau of Statistics at Ottawa, under date of May 11th, 1939.

"At the present time and in the past the comparability of Health Statistics and therefore their value, has been greatly lessened not only by the unequal lengths of the periods for which they are reported, but even because they do not cover the same period of calendar time from year to year. It is considered that a unit should be adopted by all the provinces and that all reports should be made as of this unit or of multiples of same.

"In view of this it is proposed to adopt the week as the unit and to have the reports made as of, 1. The week. 'The four week period; there would be thirteen of these in a year as follows:

1st—	Weeks	Ended	January 7, 14, 21, 28.
2nd—	"	"	February 4, 11, 18, 25.
3rd—	"	"	March 4, 11, 18, 25.
4th—	"	"	April 1, 8, 15, 22.
5th—	"	"	April 29, May 6, 13, 20.
6th—	"	"	May 27, June 3, 10, 17.
7th—	"	"	June 24, July 1, 8, 15.
8th—	"	"	July 22, 29, August 5, 12.
9th—	"	"	August 19, 26, September 2, 9.
10th—	"	"	September 16, 23, 30, October 7.
11th—	"	"	October 14, 21, 28, November 4.
12th—	"	"	November 11, 18, 25, December 2.
13th—	"	"	December 9, 16, 23, 30.

"The 31st day of December would arbitrarily be included in the week ending January 7th making this an eight day week. In Leap Year, the 29th day of February would be included in the week ended March 4th, making this also an eight day week. During 1939 these weekly periods all end on Saturday. At present all but two provinces end their reporting week on each Saturday of the year and they would continue to do so for the remainder of 1939; they would then change their reporting week to end on each Sunday for the weeks of January and February 1940, and because 1940 is a Leap Year, the remainder of the weeks for that year would end on a Monday. The weeks for 1941 would end on Tuesdays, and for 1942 and 1943 on Wednesdays and Thursdays respectively.

"In Manitoba, your week ends on a Friday, it would be necessary for you as soon as convenient to have your week end on Saturday for the remainder of 1939."

In view of this request we are endeavouring to alter our records, and consequently instead of the reports on communicable disease being sent out to cover the calendar months they will cover the four week period as set out in Mr. Russell's letter.

The last four week period ends on May 20th. Thus if this report is to be used in the bulletin there will be some adjustment necessary in reporting the communicable disease in the next issue of the "Manitoba Medical Association Bulletin." The last calendar month that will be used I believe is for the month of April, 1939. In order to straighten the matter out in the next issue it will be necessary to report only for the three week period from May 1st to May 20th and a report for that purpose will be prepared for you separately. —C.R.D.

DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of March, 1939

URBAN—Cancer 57, Influenza 14, Tuberculosis 14, Pneumonia (all forms) 7, Lobar Pneumonia 6, Syphilis 4, Typhoid Fever 1, all others under one year 9, all other causes 159, Stillbirths 13. Total 284.

RURAL—Cancer 29, Influenza 22, Tuberculosis 15, Pneumonia (all forms) 12, Lobar Pneumonia 7, Diphtheria 2, Syphilis 1, Erysipelas 1, all others under one year 29, all other causes 161, Stillbirths 21. Total 300.

INDIAN—Tuberculosis 15, Pneumonia (all forms) 10, Influenza 2, Lobar Pneumonia 2, Syphilis 1, all others under one year 12, all other causes 8. Total 50.

Medical Library
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The Practitioner — February, 1939

Midwifery and the General Practitioner. By Sir Ewen MacLean, M.D., F.R.C.P., F.C.O.G., Past President of the Royal College of Obstetricians and Gynaecologists; Emeritus Professor of Obstetrics and Gynaecology, Welsh National School of Medicine.

Ante-Natal Care in General Practice. By W. H. F. Oxley, M.R.C.S., F.C.O.G., Honorary Medical Officer and Lecturer in Midwifery, East End Maternity Hospital.

Delayed Labour. By Arnold Walker, M.A., M.B., F.R.C.S., F.C.O.G., Obstetrical Surgeon, City of London Maternity Hospital; Gynaecological Surgeon, Grosvenor Hospital for Women, Miller General Hospital, and Harrow Hospital; Assistant Gynaecological Surgeon, West London Hospital; Member, Central Midwives Board.

The Diagnosis and Treatment of Disproportion. By W. C. W. Nixon, M.D., F.R.C.S., Surgeon to Out-Patients, Soho Hospital for Women; Obstetric Consultant, London County Council; late Professor of Obstetrics and Gynaecology, University of Hong Kong.

The Management of the Puerperium and its Minor Disturbances. By A. H. Davidson, M.D., F.R.C.P.I., F.C.O.G., Master of the Rotunda Hospital, Dublin; Professor of Midwifery, Royal College of Surgeons in Ireland.

The Equipment and Instruments for Midwifery in General Practice. By John Beattie, M.D., F.R.C.S., M.C.O.G., Assistant Physician Accoucheur, St. Bartholomew's Hospital, London.

Diet in Health and Disease: XX.—Breast Feeding. By C. K. J. Hamilton, M.C., B.M., F.R.C.P., Physician-in-charge of Children's Department, Charing Cross Hospital.

Immediate Surgery in Air Raids; Work in a Casualty Clearing Station. By Philip H. Mitchiner, C.B.E., M.D., M.S., F.R.C.S., Honorary Surgeon to H.M. the King; Surgeon to St. Thomas's Hospital.

Decompression of the Bladder. By Hamilton Bailey, F.R.C.S., Surgeon, Royal Northern Hospital; Surgeon and Urologist, Essex County Council.

The Psychological Factor in General Practice. By M. O. Raven, D.M., M.R.C.P., Physician, Ramsgate General Hospital.

Solutions Used in the Injection Treatment of Hernia. By Maurice Lee, M.B., F.R.C.S., Assistant Surgical Officer, Willesden General Hospital.

The Practitioner and His Accounts. By Gordon Lowe.

The British Journal of Urology — March, 1939

Perinephric Abscess. By J. E. Semple, F.R.C.S., Honorary Surgical Registrar, All Saints' Hospital.

A Case of Complicated Extrophy of the Bladder Presenting Many Unusual Features. By K. F. Russell, M.S., Senior Lecturer, Department of Anatomy, University of Melbourne.

Chyluria of Filarial Origin. By P. N. Ray, B.A., M.B., F.R.C.S. (Eng.), Additional Surgeon, Medical College Hospital, Calcutta, and S. Sundar Rao, L.M.P., Filariasis Research Worker, School of Tropical Medicine, Calcutta.

Canadian Public Health Journal — February, 1939

Epidemiology and Etiology of Pneumonia. By A. L. McKay, B.A., M.B., D.P.H., Director, Division of Preventable Diseases Department of Health of Ontario.

Pneumonia in Ontario. By A. Hardisty Sellers, B.A., M.D., D.P.H., Department of Health of Ontario, and Department of Epidemiology and Biometrics, University of Toronto.

Antipneumococcus Rabbit Serum in the Treatment of Pneumonia. By W. P. Warner, M.B., Medical Service, Toronto General Hospital.

The Serum Treatment of Pneumococcal Pneumonia. By H. I. Kinsey, M.B., F.R.C.P.(C.), Toronto.

Age Distribution of the Population in Relation to Mortality. By M. C. MacLean, M.A., Chief, Division of Social Analysis Dominion Bureau of Statistics, Ottawa.

Treatment of Lobar Pneumonia with Antipneumococcus Rabbit Serum. By E. A. Broughton, M.B., St. Michael's Hospital, Toronto.

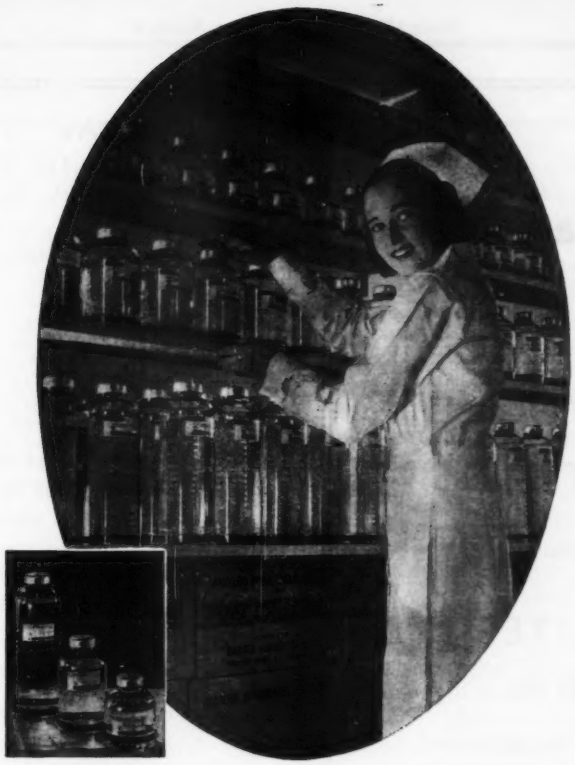
Further Observations on Brucellosis in and around Vancouver. By C. E. Dolman, Vivienne Hudson and D. G. B. Mathias.
From the Provincial Board of Health, University of British Columbia, and Connaught Laboratories, University of Toronto.

Social Services and Public Health. By Ernest H. Blois, Director of Child Welfare, Mothers' Allowances and Old Age Pensions, Nova Scotia.

OBITUARY

DR. HENRY HERBERT ELLIOTT

Dr. Henry Herbert Elliott, former Commissioner of Manitoba, died at The Pas, Manitoba, on April 24th, in his 67th year. He was born at Bayfield, Ontario; graduated from Queens University in Medicine in 1898; practiced in Seeley's Bay, Ont. till 1912. In that year he came to The Pas to open up the Out-Post Customs Service. In 1918 he went to Emerson in charge of Port Customs; resigned in 1920 and went to Rapid City where he resided till 1925, when he was appointed Commissioner to Northern Manitoba.



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THE MANITOBA MEDICAL ASSOCIATION REVIEW

Vol. XIX., No. 7, July, 1939.

CONTENTS

Clinical Section

Recent Advances in Medicine*

By

F. GERARD ALLISON, B.A., M.D. (Man.)
M.R.C.P. (Lond.)

Demonstrator in Medicine, University of Manitoba
Assistant Physician, Winnipeg General Hospital

This subject can be discussed under the following headings: Drug therapy, reversals in treatment, and advances in technical methods.

Drug Therapy

Sulphanilamide Compounds. These drugs constitute, in my opinion, the greatest therapeutic advance in this century. Sulphanilamide itself is effective against the haemolytic streptococcus, meninogococcus, gonococcus, B. coli, actinomyces, malarial parasites and the infective agent in trachoma. Patients with severe infections are given approximately 75 gr. a day, attempting to reach a blood level of 10 mgm. of sulphanilamide per 100 cc. Mild infections can be controlled by much smaller doses, for example, in pyelonephritis the urine can be cleared of pus on 10 gr. three times a day for a few days. Relapses are apt to occur. In some conditions sulphanilamide works better if combined with appropriate specific sera, e.g. in meningococcal meningitis.

Neoprontosil oral has been shown at the Mayo Clinic, Rochester, U.S.A., to have a dramatic effect on ulcerative colitis, but the work is too recent to estimate the permanence of the improvement.

Sulfapyridine or "M & B 693" or "Dagenan" promises to have a greater effect on mortality tables than any of the other compounds of sulphanilamide. The first English series of 100 cases of pneumococcal pneumonia treated by the drug had a mortality rate of 8%. The control series of alternate cases had 27% deaths. A recent carefully typed series of 100 American cases treated by sulfapyridine had 4% of deaths. It seems probable that the expensive, troublesome and occasionally dangerous serum therapy for pneumonia will soon be outmoded, or only used in combination with sulfapyridine in selected cases. The adult dose is 2 grams at once followed 1 gram 4 hourly till the patient improves, when the dosage can be reduced. Sulfapyridine works as well as sulphanilamide in streptococcal and meningococcal infections. It has helped a few cases of staphlococcal bacteremia. Experimentally it is effective against Friedlander and B. Welchii infections. The most troublesome toxic effect of sulfapyridine is nausea. This may be reduced by giving it as a powder in milk or apple sauce. A new sodium salt of sulfapyridine can be given in 2% solution by rectum. All the sulphanilamide compounds are unpleasant to take, and there is a risk of the patient developing haemolytic anaemia or agranulocytosis in the first week of treatment. Hence they should not be used in trivial conditions. Sulphates and eggs should be avoided with all forms of sulphanilamide to avoid risk of sulphaemoglobinaemia. The methaemoglobin cyanosis which frequently occurs can be overcome by administering 2 grains of methylene blue four hourly. This has the property of reconverting methaemoglobin to haemoglobin. Methylene blue is also useful in carbon monoxide poisoning.

Ergotamine Tartrate. ½ mg. subcutaneously has been shown to reduce to normal in 70% of cases the excessive pulsation of the temporal artery on the affected side in migraine, and stop the headache within an hour. It has no effect on the frequency of attacks. It should not be used oftener than once a week on older patients to avoid the risk of ergotism and gangrene. The first injection should be given in two doses in case of unpleasant reactions. Atropine 1/100 will counteract bad effects. Cases which do not respond to ergotamine may be relieved by the inhalation of 100% oxygen for an hour. Ergotamine will also arrest most attacks of supraventricular paroxysmal tachycardia.

Prostigmin was introduced as a very effective but expensive treatment for myasthenia gravis, but its widest field of usefulness is in paralytic ileus. The administration of 2 cc. (5 mg.) subcutaneously every 2 hours or oftener will often cause the count of peristaltic sounds to rise from 6 per minute to 20 per minute by the end of the day, when evacuation occurs. It is particularly useful as a prophylactic measure in doses of 1 cc. 4 hourly. This treatment can be combined with small doses of morphine to stimulate the gut and a nasal stomach tube or a Miller-Abbott tube.

Nitroglycerine has long replaced amyl nitrite as the drug of choice in angina pectoris. It is not so widely known that when administered before exertion it will prevent an attack. But its most recent use is in gall bladder colic. Experimentally it relaxes the sphincter of Oddi, while morphine causes spasm. Clinically it is effective in relieving over half the cases of gall bladder colic, particularly those not due to stone. It can be self-administered as often as desired. Nitroglycerine or amyl nitrite will relax spasms of the stomach or gut. This is sometimes of value to the radiologist trying to differentiate between an organic lesion and a spasm.

Protamine Insulin, which is slowly absorbed, has been widely publicized and does not require comment here. Most cases of diabetes can now be controlled by one daily injection. Newbergh has recently demonstrated that 90% of 183 obese diabetics could lead an insulin-free life with 300

* An address delivered to The Winnipeg Medical Society March 17, 1939.

gms. of carbohydrate daily, after reducing to a normal weight. The previous diabetic sugar tolerance curve came down to normal. The theory advanced is that excessive fat in the liver interfered with the deposition of glycogen.

Alfalfa Concentrate 1 *gm. with Bile Salts* 2 *gm.* daily for 4 days seems to be a good method for preventing haemorrhage in jaundiced patients. The effectiveness of the treatment can be checked by the rise in the prothrombin clotting time.

Congo Red 10 cc. of 1% solution intravenously is a harmless and frequently efficient method for arresting haemorrhage from the stomach, the lung, the kidney, etc. Congo Red causes a rise in platelets and fibrinogen and a fall in the clotting time. The exact mechanism is unknown.

Vitamin B cures peripheral neuritis due to poor dietary intake, e.g. in alcoholism, the vomiting of pregnancy, pyloric stenosis, pellagra, etc. According to some investigators who measure the blood vitamin B by a method involving the growth of a mould, there is no diminution of blood vitamin B in infective polyneuritis or in subacute combined degeneration of the cord.

Dihydrotachysterol, a derivative of ergosterol, is an effective oral drug for raising the blood calcium. In 6 severe intractable cases of tetany due to accidental parathyroidectomy there was elevation of the blood calcium to 10 mg. by the administration of 1/3 cc. t.i.d. The calcium could be maintained at the normal level by 1/3 cc. daily. No tolerance developed.

Sucrose intravenously is much superior to glucose or hypertonic saline for reducing the intracranial pressure, as the action is prolonged for 20 hours and there is no rebound of the pressure to a higher point than the original level. It also causes a marked diuresis. The maximum dose is 500 cc. of 50% sucrose.

The Metrazol or Insulin Shock treatments of Dementia Praecox have been widely publicized as improving the recovery percentage, but this is an institutional treatment to be administered by experts and needs no further comment here.

Phenobarbital gr. I t.i.d. administered postoperatively to 60 cases, with 40 controls, caused a diminution in gas pains and coughs in the treated series, who were able to leave hospital an average of 4 days earlier than the controls. This seems a harmless method for saving the patient pain and reducing his hospital bill.

Mebarol when tested in 2 epileptic colonies reduced the total number of fits to one-third of the control level on phenobarbital. It is given in 50% greater dosage than phenobarbital. The change over from one drug to the other should occupy a week.

Dilantin, a non sedative anticonvulsant, has achieved widespread popularity in the treatment of epilepsy. Of 118 Grand Mal patients 58% had no fits for 2 months. Of 74 Petit Mal patients 35% had no fits for 2 months. The drug has to be stopped in 5% of cases because of purpura. Others develop swollen spongy gums. The dosage is 1½ gr. from 2 to 6 times daily. The change over from phenobarbital should be gradual enough to last a week.

Benzedrine is well known as the active principle of an inhaler for shrinking the nasal mucosa. The drug for oral use in doses of 5 to 20 mg. is of value in narcolepsy, depression, sea-sickness, Parkinsonism and hypotension. The domestic uses include the restoration to normal of the sleepsoggy Sunday snoozer, the acquisition of super alertness by the examinee, and the revival of the sufferer with an alcoholic hangover. Administration after 3 p.m. may cause insomnia, as the effect is prolonged.

Rectal Ether is a simple and effective treatment for Status Asthmaticus, when adrenalin has lost its power. Equal parts of ether and olive oil are given rectally, one ounce of the mixture for every 20 lbs. of body weight. The patient has a long and restful sleep with easy breathing, and on awakening is usually responsive to normal doses of adrenalin, if it is required.

Salt and Cortin with low potassium intake has revolutionized the palliative treatment of Addison's Disease. Transplanting slices of foetal adrenals to the rectus sheath of Addison patients has been reported to cause remissions lasting a year. The most recent work on this disease concerns a useful diagnostic test. The urinary chlorides are estimated after a salt-free diet for 3 days. They are diminished in control cases but are still very high in Addison's Disease. This test can only be done in hospital where cortin and intravenous saline are available, in case the low chloride diet causes a crisis.

Reversals in Treatment

Phlebitis has kept patients bedridden for weeks because of the fear of pulmonary emboli. But in a large series of fatal cases of pulmonary embolus only 4% had had previously recognized phlebitis, and in all these cases the embolus had come from the good leg. The present teaching is that an inflamed vein has a firmly anchored clot. It is possible for an extension clot above the inflammation to become detached, but it is more probable that a stagnation clot in the good leg due to rest in bed will cause an embolus. In 700 ambulant cases of superficial phlebitis treated by elastoplast bandaging from the foot upwards there were no emboli. The bandaging diminishes oedema by supporting the tissues and causing a faster blood flow in the veins. Leeches applied along the course of the inflamed vein are said to cause a rapid relief of pain, redness and temperature. In old deep phlebitis exercise should be begun gradually, and the vein may be tied if extension clot emboli are feared.

Haematemesis cases are now fed instead of starved since Meulengracht published a large series of cases with 1% mortality instead of the

usual 12%. Only 4% needed transfusion. On the old treatment he observed that patients rarely died of the first haemorrhage, but usually a week or two later with the second or third haemorrhage, after they had been weakened by starvation. Meulengracht fed his patients a sort of convalescent Sippy diet with purees, 5 meals a day, with alkalis and iron. If his patients developed further haemorrhages they were much better able to withstand them. This work has been widely confirmed.

Advances in Technical Methods

Lead IV F on the electrocardiogram has raised the accuracy of cardiograph diagnosis of coronary thrombosis from about 75% to over 90%. Quite a number of cases show characteristic changes only in the fourth lead.

The Bragg-Paul Pulsator has superseded the Iron Lung. An apparatus resembling an automobile inner tube in the form of a shirt fits over the thorax and is connected to an intermittant air pump. A number of patients can be connected to the pump, and all pulsate together. The cheapness of the apparatus and the ease of nursing such patients is obvious.

The Encephalograph is an apparatus for recording electrical variations in the brain. Alpha beta and delta waves are described. Characteristic patterns are found in cases of petit mal and schizophrenia. Brain tumors are located with surprising accuracy. When the encephalograph is better understood it may be as useful in the diagnosis of diseases of the brain as is the electrocardiograph in disease of the heart.

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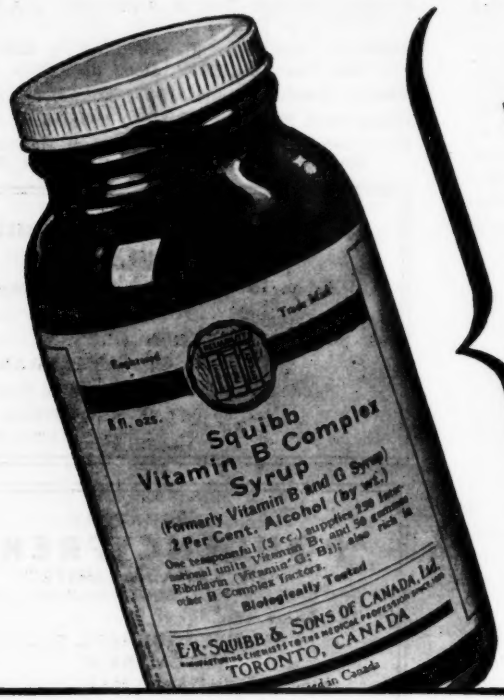

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